

UNIFORM DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS JUL 22 1960

318

Primary Registration District No. 1003

Registrar's No. 6837

-60-028293

STATE FILE NUMBER

ENDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. Louis</u>		Length of stay in 1b		c. CITY OR TOWN <u>ST. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4454 Castlemann</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Effie</u> Middle <u>C.</u> Last <u>EXTER</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1, 1867</u>	9. AGE (last birthday) <u>92</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT Home</u>		11. BIRTHPLACE (City and state or country) <u>Freeburg, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charles Frank</u>		13b. MOTHER'S MAIDEN NAME <u>Edna Varner</u>		14. NAME OF HUSBAND OR WIFE <u>E. E. EXTER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Margaret Mueller 4454 Castlemann</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Pneumo pneumonia</u> DUE TO (c) <u>332x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown						INTERVAL BETWEEN ONSET AND DEATH <u>10-14 days</u> <u>5-7 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <u>6-23-60</u> to <u>7-6-60</u> and last saw <u>her</u> live on <u>7-6-60</u> Death occurred at <u>12:40</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>William W Farley M.D.</u>				22b. ADDRESS <u>4454 Castlemann</u>		22c. DATE SIGNED <u>7-7-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>July 9, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>ST. Clair, Co., Illinois</u>	
24. FUNERAL DIRECTOR <u>Witt Bros. & Co.</u>		ADDRESS <u>2929 S. Jefferson</u>		25. DATE RECD. BY LOCAL REG. <u>JUL 7 1960</u>		26. REGISTRAR'S SIGNATURE <u>Paul Smith. M.D.</u>	

(Licensed Embalmer's Statement on Reverse Side)

S.D

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.